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WHAT A NURSE SHOULD KNOW ABOUT SYPHILIS

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DANGEROUS LESIONS

The junior nurse, like the young medical student, should be warned that not every pimple is a chancre nor every sore a mucous patch; but it is best to consider them guilty until proven innocent.

The dangerous lesions of syphilis are the moist lesions of the disease, for the causative agent, the *Spirocheta pallida*, soon loses its virulence when dry.

The moist lesions of hereditary syphilis are probably most rich in spirochetes and hence most dangerous to the attending nurse. Hereditary syphilis may be manifested by the child being miscarried at any month. A macerated foetus is the rule, and the placenta may be rich in infectious spirochetes. The child may be still-born at term; or be viable at term with the eruption of syphilis present on the skin and mucous membranes. More dangerous to the nurse is the child born with neither a scratch nor a pimple, who develops manifestations at about six weeks. In the latter cases, sores may appear singly and be difficult of recognition. The nurse should be especially cautious with any lesions of the palms, the soles, the flexures of the body, the genital and anal regions, and the mouth of any infant. The nasal discharge "snuffles," is dangerous.

A new born child may acquire syphilis from its mother during childbirth, if the mother has lesions of recent syphilis along the birth canal.

The chancre or primary lesion of acquired syphilis appears after an incubation time of from 10 to 30 days, most often 21. Ordinarily, the chancre is a single lesion, from pea size up, that may begin as a vesicle or water blister, or as a papule. The uppermost layer of the skin or mucous membrane soon peels off leaving a moist eroded surface which may later ulcerate. In the primary syphilitic sore or chancre, *Spirocheta pallida* are easily demonstrable. After ten days or two weeks, the lymph glands in the neighborhood of the chancre begin to swell.

The chancre that the nurse has most to fear is the undiagnosed chancre. Lesions about the genitals of the adult may always be suspected but an innocent appearing cold sore of the lip or a guileless

cracked nipple may harbor the infectious organism, and be the cause of infection in the careless attendant.

After a second period of incubation, usually of six weeks, during which the initial lesion may entirely disappear even with no treatment, the secondary rash appears.

The mucous patches of the mouth and of the genitals, and the hyperthropic moist skin lesions in the flexures, the so-called condylomata lata, of the secondary stage are very dangerous lesions. Skin lesions are not infectious if the epidermis is not ruptured.

The tertiary or gumma lesions contain the *Spirocheta pallida*, but the danger of becoming infected from these late lesions is negligible.

The blood of the syphilitic contains spirochetes, varying in number according to the stage of the disease. The organisms are most numerous in the florid secondary period. The spinal fluid rarely contains spirochetes.

The presence of *Spirocheta pallida* is one factor in the transmission of syphilis. The second factor is that these organisms must find a break in the skin or mucous membrane on the new host, since on the absolutely healthy, unbroken skin the spirochete will not thrive. The lack of continuity of the epidermis need not be more than microscopic in size, but the *Spirocheta pallida* will flourish and infect the individual. A third factor is that the person must be free of syphilis, because a syphilitic cannot be reinfected until he is entirely cured of his old syphilis.

Can syphilis be transmitted other than by direct contact? The answer is, Yes. The nurse should be particularly careful of all instruments that have come in contact with the patient; thermometers and vaginal tips should be especially guarded against. Eating utensils may also carry infectious material.

The nurse has often pricked her fingers with needles just used to draw blood from or to give Salvarsan to syphilitics. There are two authentic cases where such an accident has resulted in infection.

Dressings of syphilitic sores may be teeming with spirochetes.

How shall the nurse avoid infection? Need she be squeamish and hesitate to handle an open sore? No. She should, however, take sensible precautions. Among these are:

1. Good care of the hands and nails. Hang nails are especially weak points. A good stiff brush used when washing, followed by alcohol, will tell the nurse of any open places on her hands. These may be covered with collodion.

2. Gloves should be worn in any manipulation about moist lesions, such as changing dressings or douching.

3. The nurse should learn early in her training not to needlessly touch sores or ulcers.

4. The nurse should use an instrument that has been sterilized, in preference to the hands, when doing dressings. It is safer for the patient, also.

The nurse who by accident or ignorance has come in intimate contact directly or indirectly with infectious material should report to the physician on the case and he will prescribe the preventive measures to be taken. They will, for the most part, consist of thorough scrubbing with soap and water, and the application of a mercurial.

Professional infections are not unknown, and a persistent hang nail, or other non-painful and non-healing lesion about the hands should be given expert attention. The nurse should not exaggerate the danger of infection, but she must not be indifferent to its possibilities.

(To be continued)

ENLARGED THYMUS GLAND IN INFANTS

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By the way of preface it might be said that, as the title implies, I am treating this subject from the nurse's viewpoint. I shall give very few words to the clinical and anatomical findings, discussing principally the symptoms characteristic of, and treatment in cases of enlarged thymus glands. The quotation is from an article written by Dr. Howard Brayton, of Hartford, Conn. All the cases cited were treated on Dr. Goodrich's service in the Hartford Hospital, during the winter and spring of 1918.

The application of radium for an enlarged thymus is a comparatively new treatment. For the past ten or twelve years, x-ray has been successfully used, but not with such prompt results, as are found with radium. A lead capsule containing 100 milligrammes of radium is wrapped in gauze thick enough to bring the capsule one-half inch away from the skin, and is strapped to the child's chest with adhesive plaster. The exposure is of eight hours' duration, in four positions, in the shape of the four corners of a square, of two hours each. X-ray pictures taken before treatment show an enlarged thymus, while those taken afterwards show a marked decrease in size. The change in appearance and the actions of the patient immediately after the treatment are remarkable.